Speech-Language Pathology Assistant
Application Checklist

The Board has an open application process. Applications are processed once the application is complete. An application is considered complete when all of the required materials have been received by the Board. Applicants are strongly encouraged to make a copy of their application prior to sending it to the Board. An individual may only begin practicing as a speech-language pathology assistant after receipt of the limited license.

I. All Applicants Must Submit the Following

____ $100.00 Non-Refundable Application Fee
(check or money order payable to the Board of SLP)

____ A recent 2 inch by 2 inch passport size color photo (attached to first page of application)

____ Signed and Notarized Application

____ Proof of graduation from an acceptable program within the last five years

____ Law and Regulation Examination completed and returned with Application

Note: A minimum score of 75 percent is required to pass the Law Examination. The Exam can be downloaded from the Board's web site at http://www.dhmh.state.md.us/boardsahs/. Use the Forms Link to download a copy of the Exam. To complete the Examination refer to the law and regulations reference numbers included with the question. Use the Law and Regulation Links on the web site to review the appropriate statute or regulation. If you do not have access to a computer, call the Board office at 410-764-4725 and request a copy of the law and regulations. A license will **not** be issued unless the Law and Regulation Examination is passed.

II. Application for Full License by Waiver

An applicant may qualify for a waiver of the requirements for licensure as a Speech-Language Pathology Assistant if the applicant meets one of the following (A, B or C):

A. Holds a valid ASHA registration as a Speech-Language Pathology Assistant.

In addition to items in Section I, submit with application the following two items:

____ Copy of ASHA SLP Assistant Registration or
Letter from ASHA verifying SLP Assistant Registration

____ Delegation Agreement (**Form SA6**) completed by
each Supervising Speech-Language Pathologist

B. Holds a valid license, certification or registration as a Speech-Language Pathology Assistant in another State with requirements equal to or greater than Maryland's requirements.

In addition to items in Section I, submit with application the following two items:

____ Delegation Agreement (**Form SA6**) completed by each Supervising Speech-Language Pathologist

____ Verification (**Form SA8**) from the other State of licensure, certification or registration as a Speech-language Pathology Assistant including a copy of other state's law and regulations governing SLP Assistants.

C. Have been working as a Speech-Language Pathology Assistant for at least two years.

In addition to items in Section I, submit with application the following three items:

____ Letter from the Supervising Speech-Language Pathologist attesting to the dates the applicant worked as an SLP Assistant

____ Delegation Agreement (**Form SA6**) for each Supervising Speech-Language Pathologist

____ Competency Skills Check List (**Form SA7**) completed by the Supervising Speech-Language Pathologist

III. Application for a Limited License as a Speech-Language Pathology Assistant

In addition to items in Section I, submit the following documentation:

A. Education Requirement

Official transcript from college or university verifying one of the following degrees (applicant must have graduated within 5 years prior to application and transcript must be sent directly to the Board):

____ Associate's Degree from an approved SLP Assistant Program

____ Associate's Degree or higher in an allied health field from an accredited institution with minimum course work that includes at least 3 credit hours in normal speech-language development; speech disorders; anatomy and physiology of speech systems; language disorders; and phonology (Attach **Form SA2** describing required minimum coursework as stated on transcript)

____ Bachelor's Degree in Speech-Language Pathology or Communication Disorders

B. Clinical Hours Requirement (not required if applicant attended an approved SLP Assistant program)

Documentation of 25 hours of clinical observation and 75 hours of clinical assistance experience. Submit one of the following (either the Form SA3 or the Form SA4):

_____ **Form SA3** Education Institution Verification of Completion of Required Clinical Hours for applicants that completed the minimum of 25 hours of clinical observation and 75 hours of clinical assistance experience in the educational institution

_____ **Form SA4** Alternate Plan for Obtaining Required Clinical Hours signed by applicant and Supervising Speech-Language Pathologist. Please note: the required clinical hours must be completed within 60 days of the issuance of the limited license and the **Form SA5** must be submitted by the applicant no later than 90 days after issuance of the limited license. Failure to submit the **Form SA5** will result in the limited license becoming null and void.

C. Delegation Agreement (**Form SA6**) completed by each Supervising Speech-Language Pathologist

The supervising speech-language pathologist must meet either of the following two conditions:

a) be licensed in the State of Maryland; or
b) if exempt from licensure in Maryland hold the Certificate of Clinical Competency from ASHA.

To Be Submitted After Initial Limited License Has Been Issued

If a Form SA4 has been submitted to the Board the **Form SA5** is due not sooner than 60 days and not more than 90 days after the limited license is issued. The Form SA5 documents the completion of the 25 clinical observation hours and 75 clinical assistance hours. Limited licensees are encouraged to fax the Form SA5 and mail the hardcopy immediately to the Board. Limited licensees are encouraged to call the Board to confirm the Board's receipt of the Form SA5. If the Board does not receive this form before the date specified in the licensure letter the limited license is null and void; the Board will send a notice of a null and void limited license to the individual. If a limited license is null and void the individual would be required to submit another application for limited licensure.

The Competency Skills Checklist, **Form SA7**, is due after 9 months of practice under the limited license but no more than 12 months after the limited license has been issued. If the Limited Licensee has more than one supervisor the Limited Licensee must have each supervisor complete a Form SA7. The Limited Licensee is responsible for submitting the Form SA7s to the Board. If the Limited Licensee does not submit the Competency Skills Checklist the Limited License will be null and void.

Notice – Application Processing

An application is considered complete when all supporting documents and fees have been received by the Board. Final processing may take up to 15 business days. **An individual may only begin practicing as a speech-language pathology assistant after receipt of the limited license.**

Renewal of Limited License as a Speech-Language Pathology Assistant

If an individual that holds a limited license as a speech-language pathology assistant is unable to obtain at least 9 months of supervised practice as a full time limited licensee, or obtain the specified months of supervised practice as a part-time limited licensee, and/or is unable to complete the items identified in the Competency Skills Checklist the individual may renew the limited license for an additional year. The renewal form and the $25.00 renewal fee must be submitted at least 30 days prior to the expiration of the limited license. An individual with a renewed limited license is eligible for transfer to a full license provided the minimum number of supervised months has been completed and the Competency Skills Checklist has been submitted to the Board.

If an individual fails to obtain the minimum of 9 months of supervision within the two years of limited licensure the individual must wait an additional year after the expiration of the renewed limited license before the individual can reapply for a limited license as a speech-language pathology assistant.

Transfer of Limited License to Full License

An individual holding a limited license as a speech-language pathologist will be transferred to a full license provided the individual has met all the requirements and the limited licensee has been supervised for at least 9 months. The Form SA7 must be received by the Board no sooner than the 9 months of supervised practice ends and no later than 60 days prior to expiration of the limited license. The limited licensee does not need to fill out another application nor does the limited licensee have to submit another fee.

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 Fax 410-358-0273
TTY/ Maryland Relay Service 1-800-735-2258

Application for Licensure for Speech-Language Pathology Assistant

Affix Current Photo Here

Date_____

Name_____
Last First Middle/Maiden

Date of Birth _____ Social Security # _____

Residence _____
Street Apt.

_____
City State Zip Code

Phone #_____Alternate#_____ E-Mail_____

Professional Address _____
Facility or Company's Name

_____
Street Suite #

_____
City State Zip Code

Telephone # _____ Fax_____ E-mail _____

Beginning Date of Employment _____

Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?
_____ No _____ Yes If "Yes" attach full details.

For Office Use Only

Received _____ CK ( ) MO ( ) Number_____

Waiver of Requirements

A. Do you hold a valid American Speech-Language-Hearing Association Registration as a speech-language pathology assistant?
_____ No _____ Yes If yes, date originally granted: _____
Attach copy of ASHA SLP Assistant Registration or letter from ASHA verifying registration as an SLP Assistant. Also attach Delegation Agreement (**Form SA6**) completed by each supervising speech-language pathologist.

B. Do you hold a valid license, certification or registration as a speech-language pathology assistant in another state? _____ No _____ Yes

If yes, list State(s): _____ _____ _____ _____

Attach copy of SLP Assistant license, certification or registration from the State. Send affidavit (**Form SA8** – last page of application) verifying license, certification, or registration to the State(s) and ask that it be returned to the Maryland Board. Also attach Delegation Agreement (**Form SA6**) completed by each supervising speech-language pathologist.

Has any disciplinary action ever been taken against your license in any other jurisdiction?
No _____ Yes _____ **If yes, please attach full explanation**.

C. Have you practiced as a SLP Assistant for at least two years prior to submitting this application?
_____No _____Yes **If yes, attach** a letter from your supervising speech-language pathologist attesting to the dates you have practiced as a SLP Assistant. **Also attach** Delegation Agreement (**Form SA6**) for each supervising Speech-Language Pathologist **and** completed Competency Skills Check List, (**Form SA7**).

Education

An applicant must have graduated within 5 years prior to application:

A. School attended: _____

Address: _____

_____

Dates Attended: From _____ To: _____

Degree Granted: _____ Date:_____

Have School send official transcript verifying education completed directly to the Maryland Board.

B. Please indicate whether you have one of the following degrees:

1. Associate Degree from an approved SLP Assistant Program? _____Yes _____No

2. Associate Degree in an allied health field with 15 hours in required minimum course work?
_____Yes _____No
If you have an Associate Degree in an allied health field, complete **Form SA2** describing required minimum coursework as stated on transcript. If the title of the course is not self-explanatory, attach catalog description or syllabus.

3. Bachelor's Degree in Speech-Language Pathology or Communication Disorders?
_____Yes _____No

C. Did your educational program include the following required clinical hours as a Speech-Language Pathology Assistant?

25 hours of clinical observation _____Yes _____ No

75 hours of clinical assistance _____ Yes _____ No

If you did not attend an approved SLP Assistant Program, attach **Form SA3** signed by the Department Chair or Clinic Director documenting the required clinical hours.

If your educational program did not include the required clinical hours, complete **Form SA4** documenting the Plan that you and the supervising speech-language pathologist have developed to complete the clinical hours within the first 60 days of limited licensure.

Pactice Setting Where Limited Licensee Will Practice

Name of Facility _____

Address: _____

_____

Phone Number:_____ Beginning Date:_____

Description of Duties:_____

_____

_____

Supervising Speech-Language Pathologist (s):

_____

Name Title

_____

Name Title

_____

Name Title

Note: A Delegation Agreement, Form SA6, must be submitted for each supervising Speech-Language Pathologist.

Please review the regulations and sign the following affirmation:

I affirm that I have read the Speech-Language Pathology Assistant regulations, including the sections specifying activities that are within the scope of practice of SLP Assistants and activities that are not with the scope of practice of SLP Assistants.

_____ _____

Signature of Applicant Date

Applicant Must Have This Affidavit Completed by a Notary Public

State of _____

City or County of _____

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit.

_____ _____

Signature of Applicant Signature of Notary

Subscribed and sworn to before this _____ day of _____

In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information:

Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary. Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

****

Race/Ethnic Identification

To further its commitment to equal access the Board of Examiners requests applicants to provide, voluntarily, the following information. This information will be used for statistical purposes only by authorized personnel.

Male _____ Female _____

Race/Ethnic Identification – Please Check All That Apply

Are you of Hispanic or Latino origin? ____ Yes ____ No (A person of Cuban, Mexican, Peurto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ___ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

2. ___ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

3. ___ Black or African American (A person having origins in any of the black racial groups of Africa.)

4. ___ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

5. ___ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Form SA2

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists,
Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 Fax 410-358-0273
TTY/ Maryland Relay Service 1-800-735-2258

Associate Degree in Allied Health Field
Verification of Minimum Required Coursework

Applicant (please type or print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

_____
City State Zip Code

Phone #: _____ Alternate #: _____

Educational Institution

Name of Institution: _____

Address: _____

Street_____

_____
City State Zip Code

Dates Attended: From _____ To _____

Associate Degree in _____ granted _____
(major) (date – mm/dd/yyyy)

Form SA2

The Board's regulations require that an applicant with an Associate's Degree in an allied health field from an accredited institution has completed at least 3 credit hours in each of the areas listed below. Please indicate the name of the course on the transcript that fulfills each requirement and **attach an official transcript showing the Associate Degree.** If the title of the course is not self-explanatory, attach catalog description or syllabus. A minimum of 3 credit hours is required in each of the following areas:

Normal Speech-Language Development

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

_____

Speech Disorders

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

_____

Anatomy and Physiology of Speech Systems

Name of Course _____

Semester Taken _____

Additional Courses in this area:_____

_____

Language Disorders

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

_____

Phonology

Name of Course _____

Semester Taken _____

Additional Courses in this area:_____

_____

Form SA3

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Educational Institution Verification of Completion of Required Clinical Hours

The Board's regulations require that the speech-language pathology assistant shall demonstrate completion of at least 25 hours of clinical observation and 75 hours of clinical assistance experience obtained within an educational institution or in one of the institution's cooperating programs.

Applicant (Please Type or Print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

_____
City State Zip Code

Phone: _____ Alternate Phone: _____

Name of Educational Institution: _____

Address: _____
Street

_____
City State Zip Code

Dates Attended (mm/yy): From _____ to _____

Verification

I verify that _____ completed the following clinical
Applicant
observation hours and clinical assistance hours during the time he/she was a student at

_____ educational institution.

25 Clinical Observation Hours Completed From _____to _____

75 Clinical Assistance Hours Completed From _____ to _____

_____ _____
Signature Title

_____ _____
Print Name Phone

FORM SA4

State of Maryland – Department of Health and Mental Hygiene

Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists

4201 Patterson Avenue, Baltimore, Maryland 21215-2299

Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Alternative Plan for Obtaining Required Clinical Hours

This form must be completed if you have not obtained the required 25 clinical observation hours and 75 clinical assistance hours from your educational institution.

Applicant (Please Type or Print)

Name:_____

Last First Middle/Maiden

Address:_____

Street Apt. #

_____

City State Zip Code

Phone: _____ E-mail_____

Supervising Speech-Language Pathologist

Name:_____

Last First Middle/Maiden

Professional Address:_____

Facility or Company's Name

_____

Street Suite #

_____

City State Zip Code

Telephone # _____

This Plan must be approved by the Board and a Limited License issued **before** any clinical observation or clinical assisting experience is obtained. Experienced gained in violation of the laws and regulations will not be accepted as having met the licensure requirements.

The Alternative Plan must ensure that the applicant will obtain the required 25 clinical observation hours and 75 clinical assisting hours **within 60 days** of the applicant's receipt of a limited License. The plan shall be designed and signed by the supervising speech-language pathologist. If the Board does not receive proof of successful completion of the hours by the end of 90 days, the assistant's Temporary License is void and the assistant will need to reapply.

FORM SA4

The 75 hours of clinical assistance shall include 100% direct supervision by the supervising speech-language pathologist of the speech-language pathologist assistant during any client contact hours. The first month of clinical hours must start after the Board approves the **Form SA4.**

Pursuant to COMAR 10.41.11.08(B) "a licensed full-time (35 hours or more a week) speech-language pathologist may not supervise more than the equivalent of two full-time (35 hours or more a week) speech-language pathology assistants." Pursuant to COMAR 10.41.11.08(C) "a licensed part-time (35 hours or more a week) speech-language pathologist may not supervise more than the equivalent of one full-time (35 hours or more a week) speech-language pathology assistant." The Board will not issue a full SLP-A license or limited SLP-A license to an applicant until it is satisfied that the supervisor noted on the Form SA4 is in compliance with the foregoing regulations.

Alternative Plan for Clinical Hours

First Month: Week One from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Two from _____to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Three from _____to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Four from _____to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Five from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Six from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Seven from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Eight from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Signature of Applicant _____ Date _____

Signature of Supervisor _____Date_____

Supervisor: (select one of the following)

( ) Holds MD License in Speech-Language Pathology
( ) Holds ASHA CCC-SLP
( ) Holds Licensure in SLP in State of _____

FORM SA5

State of Maryland – Department of Health and Mental Hygiene

Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists

4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Verification of Completion of Required Clinical Hours

The limited licensee must submit the Form SA5 to the Board when the assistant has completed the required 25 clinical observation hours and 75 clinical assistance hours. The required hours must be completed within the first 60 days of Limited Licensure. This form must be submitted to the Board by the end of 90 days of receipt of a Limited License as specified in the letter received with the limited license. If this form is not submitted by the date specified in the letter enclosed with the limited licensee the limited license becomes null and void per COMAR 10.41.11.03(B)(2)(e).

Applicant (Please Type or print)

Name:_____
Last First Middle/Maiden

Address:_____
Street Apt. #

_____
City State Zip Code

Phone: _____

Supervising Speech-Language Pathologist

Name:_____
Last First Middle/Maiden

Professional Address:_____
Facility or Company's Name

_____
Street Suite #

_____
City State Zip Code

Phone # _____ E-Mail _____

FORM SA5

I verify that, _____ , a Speech-Language Pathology Assistant Applicant under my supervision has completed 25 hours of clinical observation and 75 hours of clinical assisting experience as indicated below:

First Month: Week One from _____ to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Two from _____to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Three from _____to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Four from _____to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Five from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Six from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Seven from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Eight from _____ to _____

Observation Hours _____ Assistance Hours _____

Signature of Supervisor_____Date_____

Supervisor: (check one of the following)

( ) Holds MD License in Speech-Language Pathology, License # _____
( ) Holds ASHA CCC-SLP, Certificate # _____
( ) Holds Licensure in SLP in State of _____, License # _____

If the Board does not receive proof of successful completion of the clinical hours by the end of 90 days, the assistant's Limited License is void and the assistant will need to reapply.

FORM SA5

FORM SA6

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
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Delegation Agreement

A Speech-Language Pathology Assistant or an applicant for licensure as a Speech-Language Pathology Assistant must file a Delegation Agreement with the Board. A separate agreement must be filed for **each** supervising Speech-Language Pathologist under whom the SLP Assistant will be working. Each Delegation Agreement must be re-filed at the time of license renewal.

Speech-Language Pathology Assistant Information:

Applicant's Name:_____

Mailing Address:_____

_____

Day Phone: _____ Evening Phone:_____

If licensed as an assistant, Maryland SLP Assistant License Number:_____

Supervising Speech-Language Pathologist

Name:_____

Address:_____

_____

Day Phone:_____ Evening Phone: _____

Maryland SLP License Number:_____ and/or ASHA Number: _____

Facility Information (where the SLP Assistant Limited Licensee will be practicing)

Facility Name:_____

Facility Address:_____

_____

Contact Person: _____ Phone: _____

FORM SA6

Will the supervising Speech-Language Pathologist be responsible for the practice of the SLP Assistant at additional facilities? _____Yes _____No

If yes, please indicate the additional facilities and their addresses here:

_____

_____

_____

_____

Delegation Agreement

The Speech-Language Pathology Assistant named in this Delegation Agreement is authorized to assist the supervising Speech-Language Pathologist named in this agreement in the implementation of speech-language pathology treatment goals and related activities as outlined in the SLP Assistant Regulations (COMAR 10.41.11) under the direction of the supervising SLP at the above named facility(ies).

The Supervising Speech-Language Pathologist agrees to supervise the SLP Assistant according to the standards outlined in the COMAR regulations.

The SLP Assistant agrees to perform only those activities authorized in the COMAR regulations.

The SLP Assistant agrees to notify the Board if this Delegation Agreement is no longer valid.

_____ _____

Signature of SLP Assistant Date

_____ _____

Signature of Supervising SLP Date

FORM SA7

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Competency Skills Checklist

At the beginning of the Assistant's Limited Licensure:
The Supervising Speech-Language Pathologist and the Speech-Language Pathology Assistant should review the Competency Skills Checklist at the beginning of the period of limited licensure and periodically thereafter. Discussion of the skills required and review of the Assistant's progress towards acquiring these skills can prove useful throughout the limited licensure period. Using the Checklist as a learning tool will provide clear goals for the Assistant and lead to the successful completion of the Checklist at the end of the nine months of supervised practice.

After 9 months of supervised practice:
The Competency Skills Checklist is to be completed by the supervising Speech-Language Pathologist after the Speech-Language Pathology Assistant has completed a minimum of nine (9) months of supervised practice under a limited license. Completion of the Checklist verifies that the Assistant has acquired the skills and knowledge needed to receive a full license as a Speech-Language Pathology Assistant.

The Speech-Language Pathology Assistant shall submit the completed Competency Skills Checklist to the Board at least 60 days before the limited license expiration date.

FORM SA7

State of Maryland – Department of Health and Mental Hygiene
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Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Competency Skills Checklist

Speech-Language Pathology Assistant:_____

Supervising Speech-Language Pathologist:_____

Directions: The supervising speech-language pathologist marks Yes or No to indicate that the assistant is competent and meets the following criteria. If the supervisor marks "not applicable" (N/A), the supervisor must include an explanation.

I. Interpersonal Skills:

Standard: The speech-language pathology assistant actively demonstrates cooperation, adaptability, and effective communication.

1. Criteria: Deals effectively with the attitudes and behaviors of the patients/clients

	Yes	**No**
a. Maintains appropriate patient/client relationships	_____	_____
b. Communicates effectively and with sensitivity the needs of the patient/client, family and caregivers	_____	_____
c. Addresses/considers patient/client and significant others cultural needs and values	_____	_____
d. Demonstrates insight into patient/client and caregivers attitudes and behaviors	_____	_____
e. Refers patient/client/caregivers/other professionals to the supervising speech-language pathologist when appropriate	_____	_____
f. Other:_____	_____	_____

2. Criteria: Communicates and interacts effectively with supervisor	**Yes**	**No**
a. Accepts and responds appropriately to constructive criticism	_____	_____
b. Requests assistance from supervisor appropriately	_____	_____
c. Actively participates in interactions with supervisor	_____	_____
d. Other:_____	_____	_____

II. Personal Qualities:

Standard: The speech-language pathology assistant demonstrates professional behavior and confidentiality.

1. Criteria: Demonstrates behaviors of a dependable team member, which may include:	**Yes**	**No**
a. Arrives punctually to appointments with prepared assignments	_____	_____
b. Submits documentation on time	_____	_____
c. Completes assigned tasks within designated treatment session	_____	_____

2. Criteria: Demonstrates appropriate conduct in the work environment, which may include:

a. Maintains confidentiality of client information at all times	_____	_____
b. Maintains professional appearance for work environment	_____	_____
c. Recognizes own professional limitations and performs within the boundaries of training and job responsibilities	_____	_____

III. Technical-Assistant Skills

Standard: The speech-language pathology assistant assists the therapist in providing adequate treatment.

1. Criteria: Maintains a facilitating environment for all tasks	**Yes**	**No**
a. Adjusts environment to facilitate learning (i.e. lights, noise, etc)	_____	_____
b. Organizes treatment space appropriately	_____	_____
c. Other _____	_____	_____
2. Criteria: Selects prepares and presents materials effectively		
a. Selects and prepares appropriate treatment materials	_____	_____
b. Selects treatment materials based on clients age, needs, culture and motivation	_____	_____
3. Criteria: Complies with documentation standards		
a. Documents treatment plans and protocols accurately, completely and concisely for the supervising speech-language pathologist	_____	_____
b. Documents client progress and performance to supervisor	_____	_____
c. Signs documents and assures co-signature when required	_____	_____
d. Prepares and maintains client records, charts, graphs, objective data as directed by the supervisor	_____	_____
4. Criteria: Provides assistance to the supervising speech-language pathologist		
a. Assists the supervisor as directed during assessments by the speech-language pathologist	_____	_____
b. Assist with informal documentation	_____	_____
c. Schedules activities appropriately	_____	_____
d. Participates with the supervisor in research projects	_____	_____
e. Participates in in-services training	_____	_____
f. Participates in public relations programs	_____	_____
g. Performs checks and maintenance of equipment	_____	_____

IV. Screenings

Standard: The speech-language pathology assistant will provide appropriate screening procedures.

1. Criteria: Administers screening tools appropriately as directed by the supervisor for communication and/or swallowing disorders which may include:	**Yes**	**No**
a. Differentiates correct vs. incorrect responses	_____	_____
b. Completes screening protocol form accurately	_____	_____
2. Criteria: Manages screening		
a. Reports any difficulties encountered with screening procedures	_____	_____
b. Schedules Screenings	_____	_____
c. Organizes screening materials	_____	_____

3. Criteria: Communicates results to supervising speech-language pathologist

a. Seeks guidance when appropriate	_____	_____
b. Provides descriptive behavioral observations that contribute to results	_____	_____

V. Treatment

Standard: The speech-language pathology assistant provides appropriate treatment resulting in optimal client improvement.

1. Criteria: Performs treatment tasks as outlined by the supervisor	**Yes**	**No**
a. Accurately and efficiently follows treatment plans developed by the speech-language pathologist	_____	_____
b. Incorporates feedback from speech-language pathologist for modifying own behavior with the client, caregivers and other professional staff	_____	_____
2. Criteria: Manages client behavior and provides appropriate treatment		
a. Maintains on-task behavior	_____	_____
b. Provides appropriate feedback to the client as to the accuracy of the response	_____	_____
c. Uses feedback and reinforcement that are consistent, discriminating and meaningful	_____	_____
d. Gives direction and instructions that are age, education and culturally appropriate	_____	_____
e. Implements treatment objectives/goals in specified sequence	_____	_____
f. Applies behavior modification and other reinforcement behavior appropriately as designated by the speech language pathologist	_____	_____
3. Criteria: Demonstrates knowledge of treatment objectives and plan		
a. Demonstrates understanding of client disorder and needs	_____	_____
b. Identifies correct vs. incorrect responses	_____	_____
c. Identifies client behaviors which demonstrate an improvement in function	_____	_____
d. Accurately reports completion of tasks	_____	_____

I verify _____

Speech-Language Pathology Assistant has completed nine (9) months of supervised practice as a Speech-Language Pathology Assistant under my supervision and has obtained the knowledge and skills needed to obtain a full license as a Speech-Language Assistant.

_____ _____

Supervising Speech-Language Pathologist Date

FORM SA8

Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Affidavit To Be Completed By Licensure Board

This portion of the form is to be completed by the Speech-Language Pathology Assistant:

Please verify _____ licensure _____ certification or _____ registration as a Speech-Language Pathology Assistant in your State for:

_____

First Name Middle Last Name

Date of Birth _____ Social Security Number _____

License/Certificate/Registration Number: _____

This portion of the affidavit is to be completed by the Board:

License/Certificate /Registration Number: _____ Date Issued: _____

Is License/Certificate/Registration in good standing? _____

Expiration Date: _____

Please provide basis for qualifying for license/certificate/registration as a Speech-Language Pathology Assistant in your state that this person met (e.g. educational requirements, practice requirements, examination, etc.)

_____

_____

Please attach law and regulations governing Speech-Language Pathology Assistants for your state.

Has License/Certificate/Registration ever been suspended or revoked? No _____ Yes _____

If yes, please explain why or attach additional explanation.

_____

_____

Has License/Certificate/Registration been reinstated? _____

Has disciplinary action ever been taken against this person? _____ If yes, please explain why or attach additional explanation.

_____

_____

Is there any derogatory information on file concerning this person? Yes _____ No _____

If yes, please explain or attach additional explanation.

_____

_____

Signature _____ Date _____

Title _____

State Board of _____

State of _____

State Seal Here

FORM SA8